OBSTACLES SCHOOL-GOING FEMALE ADOLESCENTS IN GWERU FACE IN TRANSLATING HIV/AIDS KNOWLEDGE AND ATTITUDES INTO HIV PREVENTIVE SEXUAL BEHAVIOURS

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Declaration

I, the undersigned, hereby declare that the work contained in this assignment is my own original work, and that I have not previously, in its entirety or in part, submitted it to any university for a degree.

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Abstract

The vulnerability of female adolescents to HIV/AIDS has been widely documented with little effort being made to investigate the obstacles that these female adolescents actually face in translating HIV knowledge and attitudes into HIV preventive behaviours. The researcher randomly selected 120 school going female adolescents aged between 14-19, from six secondary schools in the Gweru District in an effort to assess their levels of knowledge on HIV/AIDS and their attitudes towards HIV prevention. The study aimed to uncover the obstacles the female adolescents face in practicing HIV preventive sexual behaviours. Inferences drawn from the study point to the fact that although female adolescents may have high levels of knowledge on HIV/AIDS and positive attitudes towards HIV prevention, there are cultural and religious values that promote male dominance in patriarchal societies and female docility thereby leaving little or no room for females to negotiate HIV prevention in sexual relationships. Poverty- driven economic dependency on men, orphan hood, peer pressure, lack of support from parents and guardians on issues to do with their sex and sexuality, lack of skills to be assertive and negative attitudes of health service providers were some of the barriers the female adolescents face as they try to pave their way in to safe motherhood.

Opsomming

Die kwesbaarheid van vroulike adolessente aan MIV/vigs is wyd gedokumenteer met min moeite wat gemaak word die struikelblokke te ondersoek dat hierdie vroulike adolessente werklik gesig in die vertaling van MIV kennis en gesindhede in MIV voorkomende gedrag. Die navorser lukraak gekies 120 skoolgaande vroulike adolessente tussen die ouderdomme van 14-19, van ses sekondêre skole in die Gweru-distrik in 'n poging om hulle vlakke van kennis oor MIV / vigs en hul houding teenoor MIV-voorkoming te evalueer. Die studie is daarop gerig om die struikelblokke ontbloot die vroulike adolessente gesig in die beoefening van MIV voorkomende seksuele gedrag. Gevolgtrekkings waartoe die studie verwys na die feit dat alhoewel vroulike adolessente kan 'n hoë vlakke van kennis oor MIV / vigs en 'n positiewe houding teenoor MIV-voorkoming, is daar kulturele en godsdienstige waardes wat die bevordering van manlike oorheersing in patriargale samelewings en vroulike handelbaarheid daardeur sodat daar min of geen ruimte vir vrouens MIV-voorkoming in seksuele verhoudings te onderhandel. Armoede-gedrewe ekonomiese afhanklikheid van mans, wees kap, groepsdruk, gebrek aan ondersteuning van ouers en voogde op die kwessies te doen het met hul seks en seksualiteit, gebrek aan vaardighede om selfgeldend en negatiewe houdings van gesondheid diensverskaffers is 'n paar van die hindernisse die vroulike adolessente gesig soos hulle probeer om hul weg te baan in 'n veilige moederskap.

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CHAPTER 1

Introduction

> "*Girls and young women are highly vulnerable to HIVAIDS, and a lack of education makes them more so. Girls are at greater risk than boys because of gender inequalities in status, power and access to resources''* – World Bank

The above quote attempts to put into perspective the social and cultural issues that have contributed to young women's predisposition to the deadly epidemic that has wrecked havoc nationally, regionally as well as globally. The girl child who has been disadvantaged from birth through to death is in a double jeopardy in the face of the HIV/AIDS epidemic. She grows up in a patriarchal society where she is socialized to readily accept the domination of women by men, which place her in a compromising position with HIV/AIDS that knows no boundaries. Research has since indicated the role poverty and lack of economic alternatives leading to economic dependency of women on men, cultures with a patriarchal background that promote male dominance and female docility, lack of education, (since preference to education especially in most African societies, is usually given to the boy child), lack of or limited access to resources and power imbalance among other things, have contributed to high rates of HIV infection in females when compared to their male counterparts. The above mentioned circumstances increase the vulnerability of women in the HIV/AIDS context.

HIV behavior change communication models like the abstain or delay onset of sexual activities, avoid multiple partners by being faithful to one partner and the correct and consistent use of condoms, the so called Abstain, Be faithful, Condomise or ABC model is a case example of HIV prevention model that has been used for adolescents. This paper will look at the ABC model of HIV prevention in trying to find obstacles female adolescents of school going age are facing in using such models for HIV prevention, may be it may be leaving issues to do with adolescents unattended which could help to explain the high rates of HIV infection in these female adolescents. Gupta and Weiss (2006) for example noted that "many women have complied with their expected roles- have married early, become mothers, and remain faithful to their spouses but still become infected with HIV, with even higher prevalence in those adolescents marrying early than their peers who are sexually active but not married" (p.8). This therefore calls for

more than just advocating for the ABC model, but looking at the root causes or obstacles that make it difficult for these adolescents to be more assertive and thus practice HIV preventive sexual behaviours. Gupta and Weiss (2006 argue in favor of programmes that "are serious about making the ABCs viable behaviours for women and girls" (p.9).

1.1. Background

Recent epidemiological estimates show that adolescents in Sub-Saharan Africa account for the greatest number of new HIV infections. They account for half of the five million new cases of HIV infection worldwide, (http://unfpa.org/swp/2008/english/ch3/index). It is estimated that 6, 000 adolescents a day become infected with HIV and of these the majority are female adolescents. Research has already established that because of their biological nature, females are more susceptible to HIV infection when compared to their male counterparts. According to UNFPA (2003) "an estimated 7.3 million young women are living with HIV/AIDS compared to 4.5 million young men. Two thirds of newly infected youth aged 15-19 in sub-Saharan Africa are female" (p.23). Regional statistics indicate that Sub-Saharan Africa is top of the list of HIV infections amongst youths as 67% is made up of the female adolescents aged 15-24 years (UNFPA 2003).

In Zimbabwe most new HIV infections are among adolescents and young adults. A study conducted by the Ministry of Health and Child Welfare, National AIDS Council and United States Agency for International Development (2004) indicates that HIV infection is higher among female adolescents 15-19 years as compared to their male counterparts. Another study conducted in Murehwa, Zimbabwe in 1991-1993 showed that 42% of patients with sexually transmitted infections were female adolescents aged 15-19 years. Surprisingly, the same study shows comparatively higher HIV/AIDS knowledge and awareness levels among female adolescents than their male counterparts.

Available literature, however has not yet accounted for the causes of the gap between adolescent females seemingly high scores on knowledge and the steady rise in the rate of HIV infection among this group. The factors that contribute to the breakdown in the knowledge – motivation – action chain still need to be clearly documented.

So far no cure or vaccine for HIV has been found and this calls for more effective models of HIV prevention that positively influence health sexual behaviours and it is crucial to identify the components of such models for effective prevention efforts. The constant rise in HIV infection amongst female adolescents may suggest then that the traditional models of HIV prevention may not be as effective as hitherto believed, at least among this age group and that would need further research if effective intervention strategies were to be found Klepp, Flisher and Kaaya (2008).

Statistics obtained in a preliminary desk study of reported sexually transmitted infections and pregnancy among adolescents in Gweru District reveal that issues relating to sexuality cannot be dealt with successfully through gender blind solutions because the problem of adolescent sexuality is a gendered problem as the tables below clearly shows. The statistics were from 338 centres out of 456 which were supposed to report for the period of January to December 2008.

Table 1: STIs and AIDS related conditions among the 15-19yr age-group in Gweru District 2008

	Females	Males
Reported STIs	334	117
Reported AIDS Related Illness	105*	61*
Total	439	178

*Although room here is given for vertical transmission there is still need to look at the gap between the female adolescents and their counterparts

Table 2 Ante natal and Post natal records for the Gweru District 2008

Age Group	Under 16 weeks	16-27 weeks	28 weeks	**Total**	*HIV positive
Under 16 years	2 153	1 660	4 773	**8 584**	1 679
16-24 years	1 139	1 242	3 315	**5 696**	1 151
Total	**3 292**	**2 902**	**8 088**	**14 280**	**2 930**

*This figure does not discriminate against those who acquire HIV through vertical transmission but the fact remains these pregnant female adolescents would also have practiced unprotected sex which highly exposes them to HIV infection.

Table 1 and Table 2 clearly indicate, among other things, the fact that female adolescents will have failed to abstain as well as use condoms for pregnancy prevention, sexually transmitted

infections and worse still HIV infection. The question still remains, "What obstacles do they face should they want to practice HIV low risk sexual behaviours?"

Debates have been going on for years now on sex education in schools, while some think it is necessary for children to get the correct education on sex from the correct sources so that they are better equipped to make healthy and wise decisions, others think this topic is too taboo to be discussed and places sex ideas in the children's heads too early and thus leads to experimentation. (http://www.csun.edu/~psy453/sexed_y.htm). Those who advocate for the sex education school of thought, think that, instead of leaving children to get information on sex from friends /peers who sometimes give them wrong information which ends them by experimenting with their bodies, they should get this information in a formal way which is at school. Others feel though that while this is good for the youths, the question of what information to give and not to give remains a contentious issue given the fact that, culturally this topic has always been taboo to talk about it in African societies. With this view goes the feeling that exposing children to this information at early ages could actually lead to children wanting to find out more and thus end up experimenting again. However, what reality seems to have proved from what is on the ground seems to show that adolescents have still been indulging in unprotected sex with or without the sex education and that is where the bone of contention is. Perhaps there could be real obstacles that female adolescents may also be facing in translating knowledge and attitudes in to HIV preventive sexual behaviours.

Amidst this debate comes issues to do with how religion and culture view sex education, because all the effort that counsellors, teachers and others in support of sex education in schools may be putting in trying to empower children by giving them the correct education goes in vain as these youths have to go back to their families and communities at the end of the day where this education is condoned. Perhaps there may be need to look at how issues to do with sex and sexuality used to be dealt with in these communities. For example while parents could not talk about such issues to their children, it was the duty of the extended family the aunts and the uncles who were entrusted to provide this education. But the challenge now is that do these people have enough information about HIV/AIDS to teach the youths so they can be safe from HIV infection. These days most children go to boarding schools and thus spent about 10 months

of the year in the custody of teachers and away from their families. This also limits the time they have with both the nuclei and the extended family. May be there is need for going back to the drawing board and bring this sex education not only to the children but also to their parents, their families as well as the communities where they are coming from.

Heterosexual sex remains the major mode of HIV transmission in Zimbabwe where it is believed 92% of HIV infection is through unprotected sex. Young females remain the major victims of the HIV given the contributory factors leading to their vulnerability like their tender age as well as their biological makeup, their sex and sexuality as a human right, the poverty caused dependency on men, cultural and societal attitudes and norms which prescribe 'the appropriate' behavior for women which limit young females' powers to negotiate safer sex or resist unwanted sex, power imbalances in sexual relationships in favor of men, gender insensitive HIV prevention strategies, all of which further predisposes women to HIV infection.

The popular behaviour change communication model of HIV prevention, the ABC model that has been used in trying to help prevent HIV infection as well as re-infection can be looked at in conjunction with a few theories of Behaviour models to perhaps try and explain the gap between the knowledge these female adolescents have on HIV/AIDS, their attitude towards HIV prevention and their sexual practices. There are issues to do with delaying the sexual debut by abstaining, issues to do with being faithful to one sexual partner and the use of condoms. There is a need to look in to these issues so that possible ways of dealing with the challenges of female adolescent sexuality are considered. For example looking at this behaviour change communication strategy from which other angle may help us to appreciate its strengths and its weaknesses. Kippax (2010) argues for a social and political response alongside the biomedical prevention strategy which according to her is 'top-down' wherein individuals are given information by experts, and

> the individual is informed of the 'facts' of HIV prevention , on the basis of which, s/he, it is assumed will act rationally on the basis of the information - unless psychologically unable to do so...the focus of interventions is on behaviour as opposed to health messages focus on risks associated with intercourse rather than those associated with its social forms , e.g. marital sex or casual sex, ...change in

> behaviour is expected in a relatively short period of time following the HIV prevention/s. (Kippax, 2010 p 2).

Considering the female adolescents as in this case, it would honestly appear more like these people have no issues of sex and sexuality to be considered in the process and will therefore automatically be able to abstain, be faithful and condomise. Reality then has shown that this does not happen that way hence the need for relooking at behaviour change communication strategies. Perhaps there may be a need for going back to look at the environmental context in which these female adolescents are operating in, the education that is given, what these adolescents think about the ABC model and then the problems they are facing so that an intervention plan can then be put in place to target these obstacles.

1.2. Research problem

The high rates of HIV incidence among female adolescents despite exposure to information on HIV transmission and prevention suggests that there are some intervening factors that inhibit logical translation of knowledge and attitudes into positive behaviour change for the prevention of HIV infection. It is therefore important that such inhibitors be clearly identified and understood and factored into future behaviour modification based HIV preventive strategies. The true success level of the popular ABC approach to HIV prevention which encourages delay in the onset of sexual activity through abstinence or being faithful to one sexual partner and the consistent and correct use of a condom remains a matter of conjecture in the face of the unabated spread of the epidemic among adolescents, particularly young females. There is a need to go beyond just measuring knowledge and attitudes and to relate these to experiential sex practices among female teens. Of particular interest to the present study is why sexually active young females still in school in Gweru urban find it difficult to abstain or to negotiate for safer sex with their sex partners.

While it is appreciated that there is HIV/AIDS education in schools where it is believed children are being given a platform to learn more about the HIV/AIDS pandemic, given survival or life skills that can help them prevent HIV infection, a closer look at what is exactly on the ground may help us to appreciate the challenges these female adolescents may be facing in their fight

against HIV/AIDS. When the HIV/AIDS Education programme was started in Zimbabwe this was with the support from UNICEF whereby all the children from Grade Four through to Upper Six were supposed to have a dose of the AIDS Education through a 30 minute lesson for the Primary Children and then 35-40 minutes lesson for Secondary Schools per week. The Guidance and Counselling Department for example in most schools would be running activities for the AIDS Education Programme. UNICEF funded and produced all the teaching and learning materials which were then developed by the Ministry of Education. There was a Provincial Coordinator who was entitled to a car which would make it easier for monitoring and evaluation of the Programme.

It is unfortunate to note that this never became the case and it is therefore not surprising that at the ground no one was there to see how far the programme was running. When it would have meant educating the teachers involved first so that they are fully equipped with skills on imparting these life skills, this only happened in the early stages of the programme and the programme did not go any far. Distribution of staff to teach this new subject was also characterized by unfairness as this was given to the class teachers who are just joining the service and are inexperienced as these normally become the class teachers as senior staff members are given other senior posts. Because this new teacher is also new to the subject he/she rarely attends the lesson as he/she has no information to give and at the end of the day it would be a question of distributing text books and leaving the children alone. This only leaves the vulnerable youths sometimes to share what they have had as their experiences without adult guidance and when they leave they are prepared to experiment yet this is a transitional period from childhood moving into adulthood and as such they have limited decision making powers.

At the end of the day a female adolescent experiencing problems related to their sex and sexuality, given the cultural set up in patriarchal societies where men dominate women, some social pressures and poverty on the other hand may find the little knowledge they have on HIV/AIDS difficult to help them change their attitude towards HIV prevention. Given this scenario, how then do we come to know exactly the problems they are facing so that instead of just providing a plan, one is tailor made to suit their needs although it is known that there are no quick fix solutions to HIV/AIDS?

1.3. The research question

The research question was-:

What are the obstacles female adolescents of school going age face in translating HIV knowledge and attitude into HIV preventive sexual behaviours?

1.4. Aim and objectives

The aim of this study was to propose a set of guidelines for effective preventive intervention strategies based on and informed by a scientific understanding of the obstacles that prevent female adolescent of school going age from adopting health sexual behaviours.

The objectives were-:

- To assess the level of knowledge female adolescent students have on HIV transmission and prevention
- To analyse the attitudes of the female adolescents towards the ABC model of HIV prevention
- To assess the relationship between level of knowledge on HIV/AIDS and safe sex practices if any exist.
- To understand the challenges female adolescents face in translating knowledge and attitudes about HIV transmission and prevention into health sexual behaviour
- To provide guidelines for preventive intervention strategies that would address the challenges female adolescent students face in adopting health sexual behaviours.

CHAPTER 2

Literature Study

This section looks at literature that helps to provide insight into the research topic. It will thus begin by defining some terms that will help to understand the obstacles female adolescents of school going age face in translating HIV/AIDS knowledge and attitude into HIV preventive sexual behaviour which is what this research sought to find out. It then looks at the adolescence stage in the context of HIV/AIDS, sex and sexuality as it relates to female adolescence, behaviour change communication for HIV prevention in female adolescents and then the theoretical framework within which this study was conducted.

2.1 Definition of terms

2.1.1 Adolescence

Eerdewijk (2007) defines this stage as the in between stage where a person is moving from childhood to adulthood. In Moore and Rosenthal (1993, as cited in Eerdewijk, 2007) he/she is preparing to get into adulthood and is "preparing themselves for adult life, but not completely and fully taking up these new roles and responsibilities where a transmission to new roles is the exclusion of old ones and the adolescents must put away childish beliefs and behaviours" (p 64). For purposes of this study adolescence refers to the ages 14 to 19 years with its experiences of moving from childhood to adulthood taking into consideration the physical, psychological and emotional challenges that accompany this stage.

2.1.2 Knowledge of HIV/AIDS

Knowledge of HIV/AIDS which for purposes of this research meant the ability to know that HIV and AIDS are two different things although they are related in that HIV is the virus that causes AIDS, a condition which results when a person's body can no longer fight off infections and so as a result opportunistic infections will be taking advantage of the compromised immune system.

2.1.3 Attitude

While Montano and Kaspryzyk (2008) define attitude as personal beliefs about positive or negative value associated with a health behaviour and its outcome, this study also looks at it as the thoughts, feelings and beliefs that the respondents have with regard to HIV prevention.

2.1.4 Prevention

Prevention according to the Health Vermont fact sheet is literally to keep something from happening, it being reserved for those interventions that occur before the initial onset of disorder, which is in line with the context of this paper as it explores why it is difficult for female adolescents to practice health sexual behaviours so to prevent HIV infection.

2.2. Review of Related Literature

There are diverse theories from psychology, sociology and social anthropology that attempt to explain human behaviour in terms of the interaction of various exterior environmental factors and those internal to the human subject. Some theorists focus on the process by which human beings learn new behaviour and others explain human behaviour in terms of stimulus–cognition-response chains. These approaches seem to share a common objective of seeking to establish models for prediction and control of future human behaviour. The present study is concerned with uncovering factors that weaken the predictive capacity of the Knowledge, Attitude and Practice/Behaviour (KAP) model when applied to the ABC approach in HIV prevention. The KAP model purports that exposure to health education automatically leads to adoption of health behaviour choices (Kleep, Flisher & Kaaya, 2008). Proponents of the KAP model argue that exposure to health education leads to increased knowledge of related health consequences of certain behaviours. The model assumes that this then positively predisposes the individual towards health sexual behaviours, which in turn is meant to reduce the risk of HIV infection. The KAP model assumes that a change in attitude would logically lead to a positive change in behaviour. However, research conducted to date tends to be sceptical about the existence of a strong association between knowledge and attitudes on health, on the one hand and health seeking behaviour on the other, (Aaro et al., 1986; Osler and Kichoff, 1995). The KAP model assumes a substantially positive correlation between attitudes and behaviour as it focuses on how attitudes determine behaviour. Those studies which identify circumstances and conditions under which attitudes could be predictive of behaviour generally point out knowledge and attitudes as not being the only predictors of health behaviours (Kleep et al., 2008).

In a study conducted to investigate the effectiveness of HIV/AIDS knowledge on HIV related behaviour in Trinidad, Norman and Carr (2003) found out that there were very low levels of consistent condom use despite high levels of HIV/AIDS knowledge. Although Norman and Carr

(2003)'s study concentrated on adults, lessons can be learnt that knowledge on HIV/AIDS alone does not yield the required behaviour change in sexual relationships of adults. Norman and Carr (2003)'s study concludes that cultural specificities and other circumstantial factors play an important part in affecting behaviour and should therefore be considered in prevention programme design.

In another study, which focussed on the gap between motivation and action in condom use among drug users, van Empelen, Hoebe, and Jansen (2003) also found that other enactment factors were far more important in predicting sex behaviours. Though this research was conducted among drug users the findings could also be applicable in seeking to understand how other variables interact with different levels of knowledge and attitudes on HIV/AIDS among female adolescents. According to the findings of this study there was no motivation to use condoms in steady relationships and there were several identified enactment factors that inhibited condom use despite the high intention to condomise. Abraham et al., cited in van Empelen et al., (2003) acknowledge four concepts in an individual's intention to perform health related behaviours as self regulation, attitudes, social influence and self efficacy which are said to act as good predicators of actual behaviour. The same study also quotes Bartholomew et al., (1998, 2001) on the importance of identifying the necessary actions to be performed in order to reach the desired goal. The study highlights the need for further research to be conducted to understand obstacles that inhibit translating intention into action, attitude into desired health sexual behaviour by specific groups including adolescents in this case.

Cultural norms and values of a given society provide an important context and framework for behaviour and action. Thus it is important to consider norms and values when planning strategies to change behaviour. In most African cultures women are expected to play a passive role in sexual relationships. This explains the disparities in sex and sexuality of women when compared to their male counterparts. A study conducted by Ajuwan, Olley, Akintolla and Ikan-Jimoh (2004) revealed the fact that little is known so far about the extent to which adolescent sexual behaviour is unwanted, non-consensual or coerced. Gupta and Weiss (2006) also specifically cites gender specific factors as contributing to the overall ease or difficulty women may experience in effectively translating knowledge into health behaviour choices. To show the

importance of using the down-top approach, James, Shaw, Morisky, Hite, and Nsubuga (2007) suggests that programme planners should listen to youths on what they think is effective in giving them information on HIV/AIDS as they try to make a difference in the attitudes and behaviour of young people through education. Schools and families need to not only give the necessary education but also the support the adolescents need especially taking into consideration their gender roles. All the research literature considered above establishes the context within which the present study seeks to investigate gender and contextual factors that may act as enhancers or inhibitors to the translation of knowledge and attitude into health behaviour choices by female adolescents.

2.2.1. Adolescence

The literature on adolescence in developing countries, and in Sub Saharan Africa in particular tells us that it is necessary to treat this period of life differently from childhood and adulthood. Adolescence is a highly transitory period of life. The number and type of changes that adolescents experience in family structure, livelihoods, schooling, community bases and identities are unparalleled in any other period. To cope with the multiple and rapid changes that occur in their lives, adolescents have specific needs for new types of decision making powers. Adolescents need 'safe places' to meet with peers and mentors, as well as resources to find alternatives to pressures to leave school, engage in illegal or unsafe work, abuse substances, marry early, have unsafe sex and exchange sex for gifts or money (Bruce & Joyce, 2006). The need for access to information to help them cope with the stress related to this transitional period while living in the era of HIV/AIDs cannot be over emphasized, hence the continued support from several studies that encourage helping students through the school system. James et al (2007) present lessons learnt from the Case of Uganda to show the importance of imparting "knowledge and values sensitive to their cultural backgrounds and religious beliefs" as well bringing "HIV/AIDS Education to children, parents and families" through the community based –education programs through informal counselling assistants (p.105). The reason why it becomes important to involve communities where these children are coming from is that in most African cultures it is taboo to talk about sex as a subject and for meaningful behaviour change communication strategies to take off everyone in the society has to be involved otherwise the

adolescent could be even be left in a dilemma when the things discussed at school are the very things they are taught not to talk about at home, which then worsens their crisis.

Important as it is for such information to be imparted to our female adolescents, it is now two decades after such prevention strategies have been put in place but the continued rise in unplanned pregnancies, STIs and HIV/AIDS cases amongst adolescents show that the strategies are not effective enough to bring about the desired change. In Zimbabwe, for example it is believed that every child in school gets a dose of Sex Education as well as HIV/AIDS Education once a week, according to one Guidance and Counselling Coordinator interviewed by the researcher The problem could be what was noted by USAID Health Policy Initiative (2008 p.13) which commented that-:

> Current strategies and programs are not reaching this population because they are operating on untested assumptions about the population itself and the nature of the risk of infection. Many assume that information and services can reach vulnerable female adolescents through urban, school or youth-centred programs, yet evidence indicates that they are not being reached.

Perhaps then this would provide a starting point for a behaviour change communication strategy that intends to target these female adolescents in question. By using the bottom-up approach such a strategy should be interested in finding out where the female adolescent's problem is from the adolescent herself. An interesting study that was conducted by Jacob et al. (2007) regarding what HIV/AIDS Education: What Youth say is effective shows that 44.1% of the participants believe that they would benefit more by getting HIV/AIDS Education from school as opposed to 5.4% who that thought it was better for parents to teach them. Bringing an intervention plan that is welcome to the targeted group is likely to bring a positive outcome.

2.2.2. Sexuality and female adolescents

Cultural and religious beliefs and values in most parts of the world are against premarital sex which unfortunately is mostly expected in females. For example in most cultures in Zimbabwe the first night after the wedding is an event most awaited for by the family as the man has a way of later announcing whether the girl was a virgin or not. Symbols like a new blanket with a hole may be sent to the bride's family to communicate absence of virginity in their daughter. The husband's virginity is not an issue; as it would appear from such practices. Tan (2002) argues

that young people' sexuality is such a sensitive issue over which moral claims are made. The assumption here is that young people, female adolescents included are not supposed to have sex and therefore the argument becomes why should they be given sex education and allowed access to contraceptive methods. However, the female adolescent is left in a dilemma as she finds herself sexually active but is being denied access to information and safe methods of expressing her sexuality. Hence it is important to help the young people to get the meaning of their sexuality by dealing with the conflict and struggle that they experience in the process. (Eedewijk, 2007).

2.2.3. Behaviour change communication strategies

Research has for a long time now placed the importance of coming up with intervention strategies that take into cognisance the importance of considering the social context of the intended beneficiary of the intervention. Gilliam, Eke, Aymer and O'Neil (2009) considered the importance of considering limitations of trying to implement change in health behaviour while disregarding social and physical environment factors "that shape the individual roles and expectations and thus their health behaviour"(p.108). This then calls for investigating first the cultural beliefs, experiences and socializing forces in the environment which include the family, peers, school and the media as these have a bearing in shaping perceptions, knowledge and attitudes of adolescents as argued by Airhihenbuwa (2000). Given an African set up like Zimbabwe for example, any successful intervention plan cannot forgo the cultural values, language, rituals and symbols which are the vehicles for transmitting knowledge from generation to generation Gilliam et al (2009).

It is not possible to speak HIV prevention as is the focus of this study, and continue to be gender blind especially given the way an African child is socialised. The issue of gender roles and expectations cannot among other things, be ignored. As it is, the gender roles define what duties are performed by men and women in a social setting and Airhinhen (1992) further argues that it is these roles that define power in heterosexual relationships. As commented by Wingood and DiClement (1992, as cited in Gilliam et al., 2000 p.108) emphasis in traditional gender roles for female adolescents is on responsibilities like caring for younger siblings and carrying out household chores that develop a sense of competency and independence and sad to note that "these competencies acquired within the family milieu may not be generalizable to those competencies required to adopt and maintain HIV prevention behaviours". Important to note is

Weeks (1995 in Gilliam et.al., 2000 p.108) contribution to this effect that most of the African cultures remain silent on the "differential power relations between women and men in which men are socialised to hold greater power than women in public spheres, a hierarchy that is often played out clearly in family and sexual relationships". It is not uncommon in an African setting for example that the boy child is respected upon birth as 'the father of the family', which gives him the respect a female child does not get. Is not surprising how this power in balance can even be experienced in child play as the boy plays the father while the girl plays the mother were the adult roles are enacted just as they see things happening in the home. Even as they grow it is socially acceptable that it is the male who proposes love and not the female, where a 'No' from the female is even taken for a 'Yes', with the belief that a girl will always say no even if they are interested. In such a setting it also is not surprising who has the right to determine when to have sex, where, with whom and how. It is with this socialisation set up in mind that the researcher agrees with Wingood and DiClement (1992 as cited in Gilliam et al., 2009 p.109) that,

> Thus gender power disparity may encourage high risk behaviour in male adolescents while limiting the ability of female adolescents to protect themselves in such situations. Several suggestions have, therefore, been made to deal with the potential conflict of sex role socialisations and developmental level which may create a sense of internal conflict. Therefore, adolescents may not be taught the modes of HIV transmission, but more importantly they must be taught how to recognize the emotions that a high risk situation is likely to elicit.

Understanding how these female adolescents perceive their exposure to HIV infection, the knowledge they have about the subject and their attitude towards HIV prevention then becomes crucial in coming up with a behaviour change communication strategy that will target the real obstacles that they have in then translating these into HIV prevention sexual behaviours This can only be achieved in a client centred approach where then the female adolescent should become part and parcel of identifying the problems and the solutions to their problems in which a bottom - up approach is more appropriate when compared with the up - down approach. An interesting study that was conducted by Jacob et.al., (2007) regarding what HIV/AIDS Education: What Youth say is effective shows that 44.1% of the participants believe that they would benefit more by getting HIV/AIDS Education from school as opposed to 5.4% that thought it was better for parents to teach them. Therefore bringing an intervention plan that is welcome to the targeted group is likely to bring a positive outcome.

2.2.4 Theoretical framework

Behaviour change theories mostly seem to concentrate more on behaviour and less on the socio-cultural context within which certain behaviour may or may not be likely. This study is informed by the social cognitive theory and the theory of gender and power to help in gaining insight to the factors that contribute to the breakdown in the knowledge – motivation – action chain. The social cognitive theory postulates that an individual's interaction with others in the environment can influence a change in behaviour as they learn by watching influential people in their lives who model behaviours and attitudes. This theory argues that self efficacy, which is the belief that the individual has the ability to perform the new behaviour emerged as the best predictor of sexual risk taking behaviour, hence the importance of focusing not only on giving information on HIV prevention but equipping them with skills and self beliefs that enable them to put information into practice when confronted with counteracting influences (Bandura, 1994). With interventions based on the social cognitive approach, Dittus, Miller, Kotchick & Forehand (2004) argues that the aim would be to "increase the female adolescent's self efficacy, to refuse sexual intercourse and to negotiate condom use" if she has to be sexually intimate (p.12). SIHLE (2004, p.1) ascertains that:

> Social cognitive theory, as applied to HIV/AIDS behaviour change, suggests that before people can change risky behaviour they need information about HIV risk, training in social and behavioural skills to apply risk-reduction strategies, knowledge about social norms, and belief that they can perform the new behaviour (self-efficacy)

The second theory informing this study is the theory of power which acknowledges the "gender based power differences in male-female relationships" which defines the appropriate female sexual conduct in such relationships. This theory, according to Sihle (2004, p.1)-:

> …considers a woman's willingness to adopt and maintain sexual risk-reduction strategies in heterosexual relationships as it pertains to how much power she has, her commitment to the relationship, and her role in the relationship. This theory suggests that difficulties arise in practicing safer sex because self-protection is often influenced by abusive partners, economic needs, values around intimacy, and norms supporting women's passive behavior in sexual relationships.

This theory moves away from the individualistic approach of the other theoretical models that works with the assumption that every individual has total control over his or her behaviour while

giving little attention to contextual factors like the power disparities and gender roles that increase the vulnerability of women and the female adolescents to HIV infection. According to this theory which was developed by Connell three structures characterize the gender and power theory and these are sexual division of power, sexual division of labour and the structure of cathexis which he refers to as social norms and affective attachments, (Winghood & DiClemente 2000). The theory acknowledges the problems that women face in trying to practice safer sex in the face of abusive sexual partners because of the power differences, 'economic needs, values around intimacy, and values that support' women docility.

CHAPTER 3

Research methodology

This section discusses the research design that was used for the present study, the sampling procedure, data collection methods and the statistical analysis of the gathered data.

3.1. Research design

The current study uses a mixed method i.e. both quantitative and qualitative approaches. It is based on data collected using the survey method, focus group discussions and in-depth interviews with key informants. A descriptive survey was used because of its 'self report method' whereby respondents are requested to provide information regarding themselves and or to describe their own behaviour, attitudes and opinions, Newman (2006). Fourie (2009) also points out among other things that surveys are especially appropriate for measuring attitudes, beliefs opinions knowledge and awareness as well as behaviour. Researcher chose this as the main instrument for the study under investigation since it seeks to describe fully the knowledge, attitudes and sexual behaviour to investigate the problem at hand.

In addition to the KAPB Questionnaire, the researcher decided to triangulate the survey method by also using in-depth interviews with key informants selected from among school teachers and health workers at surrounding clinics. A Focus Group Discussion will also be used as a follow up to the Questionnaire to elicit more sensitive information on the sexual practices of the respondents. Apart from providing a more qualitative dimension to data gathering, it also would assist as a way of cross validating the findings based on the questionnaire.

It is the researcher’s hope that identifying the obstacles these female adolescents face in translating knowledge in to HIV preventive sexual behaviours can provide insights about how HIV/AIDS preventive intervention plans can be made more responsive to female adolescents’ gender and cultural sensitivities.

To deal with the reliability and validity issues of the survey technique, firstly the researcher will incorporate different types of questions in the survey instrument to include closed ended questions, open ended questions and a five scale Likert scale type questions.

3.2. Sampling procedure

The target population was female adolescents who are still in school whose ages ranged from 14-19. The systematic sampling method was used to select six secondary schools out of a total 31 in the Gweru Urban District and then random selection was used to select respondents where 20 respondents were taken from each of the six secondary schools bringing total number of respondents to 120. The probability sampling method was used so as to strengthen internal reliability of the research and avoid the researcher's conscious or unconscious bias in coming up with the list of respondents, because of its greater chances of generating a sample that "will truly be representative of the population" and can enable the researcher to "...use powerful statistical techniques in the analysis of the data and to generalise the findings to the population", (Fourie 2009, p.438)

3.2.1 Demographic data of the respondents

Respondents were aged between 14 and 19 years of age, with 17 year olds (27.5%) dominating followed by 16 year olds (20.8%). The mean age and standard deviation of the respondents was 16.64 years and 1.371 respectively.

Table 3: Socio-Demographic characteristics of the study sample

Age of respondents

Age(years)	Number	%
14	7	5.8
15	21	17.5
16	25	20.8
17	33	27.5
18	23	19.2
19	11	9.2

Educational status

Form	Number	%
2	17	14.2
3	32	26.7
4	25	20.8
5	32	26.7
6	14	11.7

Religion

Religion	Number	%
Christianity	118	98.3
Muslim	2	1.7

Type of family where respondents come from

Type of family	Number	%
Monogamous	34	28.3
Polygamous	2	1.7
Single parent (father)	8	6.7
Single parent (mother)	21	17.5
Staying with a guardian	32	26.7
Child headed	2	1.7

The majority of the respondents were from Forms Three through to Forms Five (Lower Six) constituting 74.2%. The least represented group were the Form Six (Upper Six) female adolescents that had 11.6%.

In terms of their religious backgrounds the majority (98.3%) of the respondents came from a Christian background while 1.7% was Muslim. This perhaps helps to explain why most of the respondents are against sex before marriage as this is usually in line with the Christian values. It may also explain the negative attitudes towards condom use.

Most respondents come from a monogamous (28.3%) type of family, followed by those staying with a guardian (26.7%) and those staying with a single parent (mother) (17.5%). It is important to note here that in fact a majority of the respondents come from family backgrounds which can be described as vulnerable and socially deficient, that is those being brought up in single parent, or guardian backgrounds where both parents may in fact be missing. Such environmental factors need to be analysed and understood in terms of how they affect sex education of the adolescent.

3.2.2 Living arrangements

The bulk of the respondents stay with five or more people in their families. This group staying with five or more people in their families constituted 53.3% of the sample, followed by those staying with three to four people (29.2%). More than half (55.8%) of respondents gave a breakdown of relatives they live within the same household while 44.2% did not. Of those who responded the majority live with cousin brothers (10%), aunts (7.5%), cousin sisters (6.7%) and uncles (5.8%) only. Who the adolescent female child shares with in the immediate family environment and the nature of relationship they bear to them is important given the growing phenomenon of incestuous rape instead of enriching the adolescent's socialisation extended

family relations have also proved to be the sources of sexual insecurity for the female adolescent when male relatives betray the relationship of trust by sexually exploiting those they are entrusted to look after. Orthodox preventive interventions do not seem to be informed by this rich understanding the social background of parenting practices in an African setting. The main challenge comes from an over-romanticisation of the 'Ubuntu' communitarian tradition which glosses over the challenges of sex and sexuality of the female child.

3.3. Data gathering

After permission had been sought from relevant authorities, the senior women responsible for girl child issues in the secondary school assisted in assembling all the female adolescents from ages 14–19 years in each school. Since this was time for examinations, convenience sampling was used as it relies on the available subjects. The researcher outlined the purpose of the study to the group and explains how confidentiality is going to be maintained and then asks those interested in the study to remain behind. The researcher will group administer the questionnaires so that she can clarify instructions and questions that respondents may have, can 'control circumstances under which questionnaires are completed' and 'questionnaires can be completed in a relatively short period of time with limited amount of effort', Fourie (2009, p 451).

3.4. Methods of data analysis

Statistical analysis was performed using the Computer Programme Statistical Package for Social Science (SPSS) Version 11 on 120 questionnaires to compute statistical measures of reliability, variability, central tendency and to test patterns and relationships between and among variables. The collected information will be organized under the following themes, respondents' demographic data, knowledge on HIV/AIDS and prevention, Attitudes towards HIV Prevention, Sexual Practices and the obstacles faced in efforts to prevent HIV infection to make it easier to interpret findings. Relevant reports and tables will be used to present the information. Pearson product moment correlation coefficients will be calculated to measure the relationship between the respondents' knowledge and attitudes towards HIV prevention and their sexual behaviours. A sample of the questionnaire is available in the Appendix.

CHAPTER 4

4. Results and discussion

4.1 Results

4.1.1. Knowledge and awareness on HIV/AIDS

It is interesting to note that respondents freely answered the section of the questionnaire on knowledge and awareness unlike the one on their sexual behaviour practices. Almost all respondents (97.5%) indicated being aware of HIV/AIDS. Of these 82.5% indicated that there is a difference between HIV and AIDS. Table 4 below gives a breakdown on how people believe HIV is transmitted.

Table 3: Views on how people get HIV

How do people get HIV	Number	%
unprotected sex with an infected partner	10	8.3
kissing an infected person	1	0.8
unprotected sex & transfusion	2	1.7
unprotected sex, transfusion, kissing, cuts, mosquito, mother-child	2	1.7
unprotected sex, transfusion, kissing, pricks & cuts, mother-child	8	6.7
unprotected sex, transfusion, kissing, cuts, mother-child, other	1	0.8
unprotected sex, transfusion, kissing, mother-child	2	1.7
unprotected sex, transfusion ,pricks & cuts	4	3.3
unprotected sex, transfusion, pricks & cuts, mosquito	1	0.8
unprotected sex, transfusion, pricks & cuts, mother-child	51	42.5
unprotected sex, transfusion, pricks & cuts, mother-child, other	1	0.8
unprotected sex, transfusion, mosquito, mother-child	2	1.7
unprotected sex, transfusion, mother-child	7	5.8
unprotected sex ,transfusion, mother-child, other	1	0.8
unprotected sex, kissing, pricks & cuts, mother-child	1	0.8
unprotected sex ,kissing, mother-child	1	0.8
unprotected sex, pricks & cuts	1	0.8
unprotected sex, pricks & cuts ,mother-child	14	11.7
unprotected sex, pricks & cuts ,mother-child, other	1	0.8
unprotected sex, mother to child	7	5.8
unprotected sex, transfusion, pricks & cuts, mosquito, mother-child	1	0.8
no response	1	0.8
Total	120	100.0

From table 4 above it can be noted that the majority of respondents indicated that people get HIV from unprotected sex with an infected partner, transfusion of unscreened blood, pricks and cuts with unsterilized sharp objects and from mother to child. This accounts for 42.5% of the

respondents. It can be assumed that with such knowledge if knowledge led to a positive attitude towards HIV prevention then using the ABC model for HIV prevention would yield good results looking at the percentage that knows how they can expose themselves to HIV infection.

Most respondents acknowledged having been affected by HIV/AIDS. This was noted in the numbers of their relatives who are HIV positive, living with AIDS and those who have died of AIDS related illness. From the responses 23.3% of their relatives died of AIDS related illness, 15.8% have relatives who are HIV positive while 5.8% have relatives living with AIDS. The remainder was a combination of at least two of the above. It is from this analysis that it was noted that 90% of the respondents are aware that the causative agent for HIV is a virus. Most respondents (70.8%) indicated that the body's defence system cannot fight AIDS. It was also noted that that 52.5% of the respondents indicated that you can't tell if someone has HIV by just looking at their physical appearance while 42.5% indicated that you can tell if someone has HIV by just looking at their physical appearance. The majority (45.8%) also indicated that the four body fluids that can transmit HIV are blood, semen, vaginal secretions and breast milk. Interesting to note though here is the fact that a good number still think outside appearance can be used to tell someone's HIV status and the dangers of such a belief is they can easily be fooled to think that a health looking person is HIV negative and therefore be exposed to unprotected sex with a person who is HIV positive.

4.1.2. Knowledge on HIV prevention and HIV testing

Most of the respondents (81.7%) indicated that condoms can be used to prevent HIV infection while 9.2% were against. Table 5 below gives a breakdown on the responses on how effective condoms are in preventing HIV transmission.

Table 4: How effective are condoms in preventing HIV transmission?

	Frequency	**Percent**
100%	7	5.8
90%	33	27.5
50%	14	11.7
depends on how you use them	36	30.0
don't know	28	23.3
no response	2	1.7
Total	120	100.0

The respondents in the sample indicated that the effectiveness of condoms depends on how you use them as can be depicted from the table. Of these respondents, 39.2% were against the idea that if you are faithful to only one sexual partner, you do not get HIV while 35.8% were for the idea. However 20.8% of the respondents were not too sure. The fact that there are some who professed ignorance about the use of condoms for protection against HIV and that there are also those who believe that condoms provide a fail-safe proof against HIV is worth noting and disturbing since an unformed use may be just as dangerous as no protection at all.

Almost all (98.3%) of the respondents indicated having access to information on HIV prevention. Of these 22.5% get it from counsellors, 5% from parents, 0.8% from friends, 3.3% from teachers, and 1.7% from sexual partners and the rest from a combination of any of these. The mere fact that parents and teachers who are supposed to be the key players in providing guidance to these female adolescents constitute just 8.3% leaves a lot to be desired since these come from the social institutions the female adolescents should have greater contact with.

On HIV testing, most (79.2%) of the respondents indicated that they had never been tested for HIV while 19.2% had been tested. Of the 19.2% who got tested only 1.7% went for testing with their partners, 15.8% went alone and 82.5% did not respond on this question. 42.9% of them were tested in the last 12 months, 28.6% in the last six months and 28.6% in the last three months.

Most respondents (95%) responded on the question of planning to get married in the near future. Of these respondents 34.2% indicated yes in four years to come, 34.2% indicated not having plans at all, 2.5% indicated yes in two years to come and 24.2% were not sure. Knowing one's HIV status can also act as a means to HIV prevention with the assumption that once one knows one's HIV status they can be more responsible in terms of HIV prevention. If this is related to one's intention to get married and therefore going together with one's partner for HIV testing, this could mean a positive move towards HIV prevention. But unfortunately of those who got tested only 1.7% went with their sexual partners.

4.1.3. Sexual practices

Almost all (97.5%) of the respondents responded to the question on sexual practices. This study revealed that 16.2% have indulged in premarital sex. Of these 50% of them did this between 16 and 19 years of age, 27.8% at the age of 13 to 15 years and 11.1% between 10 to 12 years. This can be noted in the following table. It needs to be pointed out that the results of this survey may be presenting a rather conservative figure of the actual levels of sexually active females at much earlier ages as the figures obtained from the local clinics have shown. The low response in this section of the questionnaire could also indicate the sensitive nature of the topic under study and hence the difficulty that may be associated with talking about such issues in addition to the cultural background that condones or regard talking about sex as taboo.

Table 5: Age of respondent at first sexual intercourse

Age(years)	**Number**	**%**
0	1	5.6
10-12	2	11.1
13-15	5	27.8
16-19	9	50.0
don't know	1	5.6
Total	**18**	**100.0**

More than a third (38.9%) of the respondents had sexual intercourse before their sixteenth birthday. Whether forced or having consented to sex at this age is a high risk factor in HIV transmission. Also the number that has agreed that they have had sexual intercourse if tallied with the figures obtained from the clinics, it only shows perhaps the importance of an ethnographic study as well as the importance of taking the study over a reasonable amount of time in addition to the methods employed for this study.

The ages of persons with whom the respondents had their first sexual intercourse with, ranges from 9 to 22 years. It would appear as if no cross generational sex is taking place, however responses given that show that sometimes indulging in unprotected sex is because one may be having sex in order to have money for survival suggests that sex is taking place between the female adolescents and older men. The following table gives a break down on the age of person with whom the respondent says had her first sexual intercourse with.

Table 6: Age of person with whom you had your first sexual intercourse with

Age (years)	Number	%
9	2	1.7
15	1	0.8
18	1	0.8
19	2	1.7
20	1	0.8
21	2	1.7
22	1	0.8
don't know	4	3.3
Total	14	11.7

This study also made an attempt to assess the proportion of female adolescents who were using condoms while having sex with partners. It was found that 50% regularly use condoms while having sexual intercourse. An attempt to find the number of sexual partners the respondent had since her first sexual encounter was made. It was found that 66.7% had one, 11.1% had more than two but less than five and 11.1% had above five sexual partners. This shows that attention on HIV prevention should not only place the emphasis on condom use only but even the reduction of sexual partners as this further predisposes the female adolescent to HIV infection and increases their vulnerability given their inability to negotiate condom use in the gendered struggle for power in sexual relationships.

4.1.4 Sexual behaviour while drunk

A smaller fraction (14.2%) of the female adolescents responded to the question. It was found that 23.5% of those who respondent had sexual intercourse while drunk. Of these 23.5%, 60% never used condoms during sexual intercourse. More information can be obtained in the following table. Alcohol usually results in impaired judgements even in the decision to have or not to have sex more so the decision to argue for use a condom let alone putting it on correctly and consistently. This could then explain for the constant rise in unplanned pregnancies, STIs and HIV prevalence rates.

Table 7: Sexual behaviour while drunk

Did you use a condom

Did you use a condom	Number	Percent
No	3	2.5
Yes	2	1.7
Total	5	4.2

Do you currently have a sexual partner(s)?

Do you currently have a sexual partner	Number	Percent
no	8	6.7
yes	8	6.7
Total	16	13.3

The last time you had sex did you use a condom?

Did you use a condom the last time you had sex	Number	Percent
no	2	1.7
yes	9	7.5
Total	11	9.2

Do you currently have more than one sexual partner (including your regular partner)

Do you currently have more than one sexual partner	Number	Percent
no	11	9.2
yes	3	2.5
Total	14	11.7

A fraction of the respondents (6.7%) who admitted having had sex, are still sexually active. With the comments that were coming from these respondents that they would not want to talk to anyone about sex as they said that this was meant to 'be their secret', it will then mean that in such a scenario no one can help our female adolescents as they try to keep up their appearance and pretend they are abstaining. It is unfortunate then that this is also how they fall prey to unproductive sexual behaviour as it now depends on the mercy of their sexual partner who research has already indicated complain of no sexual gratification if a condom is used.

From Table 8 above it can also be noted that 50% of the respondents to this question have sexual partners and 81.8% of them did use condoms the last time they had sexual intercourse. It can also be noted that 21.4 % of them currently have more than one sexual partner including their regular

partners. This shows that importance of informing them of the dangers of multiple partners has not been linked to the knowledge that they have on HIV prevention and no wonder why one respondent wrote, '...How can I be faithful to my partner when I see another attractive guy.?'

4.1.5 Sexuality and economic vulnerability

Quite an insignificant number (0.8%) of the female adolescents did exchanged money for sex and never used a condom in the process. At least the respondent shows evidence of what happens because of poverty and economic dependency on men. Research done with commercial sex workers indicate that men will pay more for having unprotected sex and should one be having sex for money then even the power to negotiate condom use becomes a nightmare. No wonder why at the end of the question paper where respondents were given space to ask any questions related to this study, one respondent indicated that, 'To be honest with you I am intelligent and have been troubled by many issues in my life as a girl (orphan). My problem and others of my age is money I have an STI but I do not know who to talk with. My private parts are being eaten up but I have no one to tell. Please help'.

Table 8: Sexual behaviour and money

Ever exchanged money for sex

Ever exchanged money for sex	Number	Percent
no	17	14.2
yes	1	.8
Total	18	15.0

If yes did you use a condom

If yes did you use a condom	Number	Percent	Valid Percent
no	4	3.3	100.0

Despite the HIV/AIDS awareness and safer sex campaigns in the country, 2.5% of the female adolescents from the survey were for the idea that indulging in unprotected sex with your partner shows that you love them. In the last 12 months 5% of them never had any sexual partner whilst 95% of them didn't respond to the question. In the last 3 months 10% of them had some sexual encounters. Of the 10%, 66.7% used condoms all the times, 16.7% never used condoms and 16.7% were no longer sure whether they did use condoms or not.

4.1.6 Sources of information on HIV/AIDS protection

Almost all the female adolescents (90%) had heard about how you can protect yourself from getting HIV, the remainder (10%) was shared equally among those who haven't heard anything about protecting yourself from HIV and those who never respondent to the question at all. Below is a table giving a breakdown of sources where the respondents got information on HIV/AIDS protection.

Table 10: Sources of information on HIV/AIDS Protection

Source	Frequency	Percent
Partner	2	1.7
parent/guardian	10	8.3
Sibling	1	0.8
Relative	1	0.8
Teacher	5	4.2
NGO staff	1	0.8
healthcare service provider	7	5.8
Media	5	4.2
partner, parent, relative, teacher, healthcare, media	2	1.7
partner, parent, relative, teacher, media	2	1.7
partner, parent, relative, NGO-staff, healthcare	1	0.8
partner, parent, teacher, healthcare, media	1	0.8
partner, teacher, healthcare	1	0.8
partner, teacher ,healthcare, media	1	0.8
partner, teacher, media	1	0.8
parent, sibling, relative, teacher, NGO-staff, healthcare, media	1	0.8
parent, sibling, relative, teacher, media	3	2.5
parent, sibling, media	1	0.8
parent, relative	1	0.8
parent, relative, teacher , media	1	0.8
parent, relative, teacher, NGO-staff, healthcare, media	2	1.7
parent, relative, teacher, NGO-staff, media	1	0.8
parent, relative, teacher, healthcare	1	0.8
parent, relative, teacher, healthcare, media	6	5.0
parent, relative, teacher, media	4	3.3
parent, relative, healthcare, media	1	0.8
parent, teacher	2	1.7
parent, teacher, NGO-staff, healthcare, media	2	1.7

parent, teacher, NGO-staff, media	1	0.8
parent, teacher, healthcare	2	1.7
parent, teacher , healthcare, media	8	6.7
parent, teacher, media	10	8.3
parent, media	3	2.5
relative, teacher, healthcare, media	2	1.7
relative, teacher, media	3	2.5
relative, healthcare, media	1	0.8
relative, media	1	0.8
teacher, healthcare	2	1.7
teacher, healthcare, media	3	2.5
teacher, media	4	3.3
NGO staff, Healthcare service provider	1	0.8
Healthcare service provider, media	3	2.5
Total	**111**	**92.5**

The fact that there is no significant source of information on HIV protection given the distribution of sources of information it can be argued that again this area remains no body's business and the female adolescents could just be coming across the information as they experience life. This can also be a barrier to HIV protection as these female adolescents will then end up succumbing to peer pressure as these may have a completely different approach and agenda in providing this information. Some respondents indicated that they would want this researcher to continue coming as they wanted to know more on the topic under investigation, 'I would like you to conduct many lessons at our school so that you can reach the girl child to be aware of the dangers of this killer disease'. Another one wrote what measures are you as counsellors taking in the prevention of this disease? And how do you reach these people in the remote areas to tell them about HIV/AIDS?' Yet another also wrote, 'to prevent HIV we need school student counsellors at schools'.

4.1.7. Perceptions about condoms

The majority (80%) of the female adolescents indicated that it is easy to say NO to sex whilst 17.5% said it was difficult. This figure almost corresponds with the number of people who admitted that they have had sex so far 16.2%, and there is perhaps an indication that these are really talking from experience as they were indicating from the open ended questions that

feelings they experience contributed to why they could not say no or even negotiate condom use. On carrying condoms around in case they have sex with their partners, 20% said it was easy while 71.7% indicated that it was not easy. Some of the reasons given when respondents were probed included that carrying condoms is a sign of loose morals.

Table 11: Sex and Condom Access

Is it easy to say NO to sex?

Is it easy to say NO to sex?	Number	Percent
no	21	17.5
yes	96	80.0
Total	117	97.5

Would it be easy for you to carry condoms around in case you have sex with your partner

Would it be easy for you to carry condoms around in case you have sex with your partner	Frequency	Percent
no	86	71.7
yes	24	20.0
Total	110	91.7

The greater percentage which indicated that they have not yet had sex could perhaps be the same ones seen here arguing that it is not easy to carry condoms around and some even indicated in the open ended questions that 'carrying them would tempt you to say you are safe and then start having sex' while some were arguing that, 'In premarital sex there is no room for thinking about condoms let alone to be seen carrying them around'. Proving guidance and support for these few who want to abstain could a way forward in HIV prevention among female adolescents.

4.1.8 Accessibility of condoms

Most (85.8%) of the female adolescents from the research sample responded to the question on the accessibility of condoms. Of these 69.9% indicated that condoms are not easily available to them, while 30.1% indicated that they are accessible. However fewer (14.2%) of the female adolescents from the research sample did not answer the question. Easy access for condoms is key to successfully translate knowledge about their use in HIV prevention. The fact that more than half of the respondents indicated that they have difficulty accessing condoms is a serious obstacle or barrier to practising safe sex on the part of adolescent females.

The following table gives information on who the female adolescents openly discuss issues to do with sex.

Table 9: With whom would you openly discuss issues to do with sexual issues

With whom would you openly discuss issues to do with sex	Number	Percent
none	11	9.2
parent/guardian	5	4.2
sexual partner	6	5.0
peers/friends	18	15.0
counsellor	13	10.8
relative	2	1.7
parent, partner, peers, teacher, counsellor	1	0.8
parent, partner, peers, teacher, counsellor, relative	2	1.7
parent, partner, peers, counsellor	1	0.8
parent/guardian, peers/friends	4	3.3
parent/guardian, peers/friends, teacher, counsellor	3	2.5
parent/guardian, peers/friend, teacher, counsellor, relative	2	1.7
parent/guardian, peers/friends, teacher, relative	2	1.7
parent/guardian, peers/friends, counsellor	5	4.2
parent/guardian, teacher, counsellor	2	1.7
parent/guardian, counsellor	3	2.5
parent/guardian, counsellor, relative	2	1.7
sexual partner, peers/friends	1	0.8
sexual partner, peers/friends, teacher, counsellor, relative	1	0.8
sexual partner, peers/friends, counsellor	4	3.3
sexual partner, relative	1	0.8
peers/friends, teacher	1	0.8
peers/friends, teacher, counsellor	6	5.0
peers/friends, teacher, counsellor, relative	1	0.8
peers/friends, counsellor	11	9.2
peers/friends, counsellor, relative	3	2.5
peers/friends, relative	2	1.7
teacher, counsellor	3	2.5
Total	116	96.7

From the table 12 it can be noted that 15% of the respondents openly discuss sexual issues with peers/friends, 10.8% with counsellors, 5% sexual partners and 4.2% with parents. The rest is either a combination of the above. It is most unfortunate to note that the sometimes misinformed peers here has proved to be the best source of support or provider of information on sex and this may mean misguiding each other if these peers are not provided with the correct information to share with the others hence the importance of peer education programmes for these female adolescents.

There is evidence from these findings in this section that respondents can freely talk about these other issues as long as it is not their sexual behaviour. It is also clear from this section that the knowledge that they have on HIV has helped them to develop a positive attitude towards HIV prevention. Quite a number (17.8%) of the respondents agree to strongly agree that there is nothing wrong with boys and girls who love each other having sex even before marriage. However most (78.3%) of them disagree to strongly disagree. This is given in table 12 below.

Table 10: Views on Premarital sex

There is nothing wrong with boys and girls who love each other having sex even before marriage	**Number**	**Percent**
strongly agree	13	10.8
Agree	8	6.7
not decided	3	2.5
disagree	27	22.5
strongly disagree	67	55.8
Total	118	98.3

There were mixed feelings on views on premarital sex, 11.6% of the respondents agree to strongly agree that there is no link between having multiple partners and the high risk of getting HIV infection while 59.1% disagree to strongly disagree.

Table 11: Link between having multiple sex partners and risk of HIV

There is no link between having multiple partners and the high risk of getting HIV infection	**Number**	**Percent**
strongly agree	1	0.8
agree	13	10.8
not sure	29	24.2
disagree	28	23.3
strongly disagree	43	35.8
Total	114	95.0

HIV/AIDS education in schools is very important in the prevention of HIV/AIDS infection

HIV/AIDS education in schools is very important in the prevention of HIV/AIDS infection	**Number**	**Percent**
strongly agree	72	60.0
agree	42	35.0
not sure	2	1.7
strongly disagree	2	1.7
Total	118	98.3

From the table 14 above, it can be noted that, the greater majority. 35.8% strongly disagree that there is no link between having multiple partners and the risk of HIV infection and only 0.8% agree with this statement. This can be taken as a good sign of a move towards HIV prevention if this knowledge could lead to a positive attitude towards HIV prevention. On the issue of sex education in schools, the same table indicates that 95% of the female adolescents also agree to strongly agree that HIV/AIDS education in schools is very important in the prevention of HIV/AIDS infection and 1.7% strongly disagree.

Of these female adolescents who agree to strongly agree that HIV/AIDS education in the prevention of HIV/AIDS infection, most (73.7%) were of the idea (agree to strongly agree) that their families (father, mother, siblings and other relatives or guardians) are important people in helping them prevent HIV infection and therefore should openly talk to them about sexual issues, 11.6% were against (disagree to strongly disagree) the idea while the remainder were not sure. One respondent had this to ask, '...why parents are not open about this disease?' Such responses provides a good basis then for an intervention plan that can target the family as the primary socialising agent who can be entrusted to impart the correct information on HIV prevention.

Table 12: Men who have sex with girls without using condoms should be arrested

Men who have sex with girls without using condoms should be arrested	**Frequency**	**Percent**
strongly agree	39	32.5
Agree	22	18.3
not sure	19	15.8
Disagree	30	25.0
strongly disagree	6	5.0
Total	116	96.7

Delaying onset of sexual activities by abstaining is an effective way of preventing HIV infection for female adolescents.

Delaying onset of sexual activities by abstaining is an effective way of preventing HIV infection for female adolescents.	**Number**	**Percent**
strongly agree	51	42.5
Agree	22	18.3
not sure	26	21.7
Disagree	9	7.5
strongly disagree	8	6.7
Total	116	96.7

Male sexual partners are the ones who should always carry condoms on them in case the two lovers decide to have sexual intercourse

Male sexual partners are the ones who should always carry condoms on them in case the two lovers decide to have sexual intercourse	Number	Percent
strongly agree	8	6.7
Agree	19	15.8
not sure	33	27.5
Disagree	36	30.0
strongly disagree	20	16.7
Total	116	96.7

From Table 15 above, it can be noted that, the fact that 50.8% agree to have men who have sex with girls without using condoms should be arrested shows the powerlessness of these female adolescents as they acknowledge the power imbalances in sexual relationships which favour men.

The majority of respondents here 60.8% agree to strongly agree that delaying the onset of sexual debut would be an effective way to prevent HIV infection. Again here this percentage need a shoulder to lean on as they believe that this could help them to prevent HIV infection and it would not be appropriate to continue to hammer on only one of the ABC strategy which is condom use when someone indicates a strong urge to abstain.

It can also be noted that 46.7% of the respondents disagree to strongly disagree that male sexual partners are the ones who should always carry a condom on them in case the two lovers decide to have sexual intercourse. This percentage could be the same percentage who is arguing for 'zero grazing' as they believe just carrying the condoms is a temptation enough to drag people into premarital sex. 22.5% agree to strongly agree and the remainder was not sure.

4.1.9. Level of knowledge on HIV/AIDS and safe sex practices

Generally level of knowledge on HIV/AIDS and safe sex practices from the study was higher. The following cross tabulation statistics provide several interesting observations about the data.

Table 13: HIV/AIDS awareness * Awareness of Condoms as a preventive tool cross tabulation

			Condoms can be used to prevent HIV infection		
			no	yes	Total
Are you aware of HIV/AIDS?	**no**	Count	0	1	1
		Expected Count	.1	.9	1.0
		% within Are you aware of HIV/AIDS?	.0%	100.0%	100.0%
		% within Condoms can be used to prevent HIV infection	.0%	1.0%	.9%
		% of Total	.0%	.9%	.9%
	yes	Count	11	96	107
		Expected Count	10.9	96.1	107.0
		% within Are you aware of HIV/AIDS?	10.3%	89.7%	100.0%
		% within Condoms can be used to prevent HIV infection	100.0%	99.0%	99.1%
		% of Total	10.2%	88.9%	99.1%
Total		Count	11	97	108
		Expected Count	11.0	97.0	108.0
		% within Are you aware of HIV/AIDS?	10.2%	89.8%	100.0%
		% within Condoms can be used to prevent HIV infection	100.0%	100.0%	100.0%
		% of Total	10.2%	89.8%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.114[a]	1	.735		
Continuity Correction[b]	.000	1	1.000		
Likelihood Ratio	.216	1	.642		
Fisher's Exact Test				1.000	.898
Linear-by-Linear Association	.113	1	.736		
N of Valid Cases	108				

a. 2 cells (25.0%) have expected count less than 5. The minimum expected count is .10.

In table 16 above, there appears to be an association between HIV/AIDS awareness and Condoms use to prevent HIV infection as the expected values, which are the values expected by chance, and the actual counts are significantly different from each other. The output provides a statistical hypothesis test for the hypothesis that HIV/AIDS awareness and Condom use to prevent HIV infection cross tabulation are independent of each other. The Chi-Square statistic (0.114) and significance level ($p > 0.05$) indicates that it is very likely that these variables are independent of each other. Thus from the results, it can be concluded that there is no relationship between HIV/AIDS awareness and condom use to prevent HIV infection.

4.2. Findings from focus group discussions

4.2.1. Attitude towards HIV prevention

The Focus Groups discussed issues to do with when they saw it proper to become sexually active and the reasons why they thought so, the circumstances girls usually find themselves in that usually lead them to having sex and whether it is easy to say yes to having sex with your boyfriend. Also discussed were the challenges that they meet as female adolescents in sexual relationships that either makes it easy or difficult to prevent themselves from HIV infection.

The value that respondents put in virginity explain the reason why most of them indicated that they had never had sex clearly indicating that there was no need for one to ever think and talk about sex and condoms 'when you are not married'. Several respondents were quoting the bible to say 'God does not allow people to have sex before marriage and so as a Christian I should wait until I get married' As to whether condoms should be easily accessible for female adolescents in case they fall prey to unplanned sex, since most of the female adolescents end up caught up in 'acquaintance rape' situations as they usually end up succumbing to the boyfriend's pressure. This group of respondents argue that it is tempting to have them around as one may then think, 'I am safe if I use a condom and gets involved with the man who will sometimes refuse to marry her'. Another respondent added, 'a condom is not 100% effective, why do scientists recommend it instead of abstaining'.

On the contrary the other group of respondents feels although they may want to protect themselves the male sexual partners do not want to use condoms and it is usually very difficult for them to ever mention a condom as 'the man may think that you are a prostitute', and so would rather play a 'good woman' who is submissive and should not be heard. These respondents share stories of how the boyfriend may invite you to their homes and lie that there will be elders around only to find yourself trapped with the boyfriend alone or sometimes his friends who will then leave the two of you alone. Under such circumstances, they agreed, '*mafeelings ako anokurumidza kukubata wobva waita',* 'meaning 'your feelings quickly overcome you and you are suddenly caught in the unprotected sex', 'It always has a magnet attraction .....', 'Feelings will force you to do it', 'you are overcome by sexual feelings and there is no time for use of condoms'. One 15year old respondent had this to say 'wanting to experience the feeling of sex, I love it so much', while another respondent said, 'Because nature will be driving its force plus money problems may lead you not to say, 'No'.

One respondent indicated that even if they are easily accessible it's 'difficult for a girl to be seen with condoms because your boyfriend may think you are sleeping around and he will associate you with a prostitute.' Yet another respondent wrote, 'having sex with your boyfriend shows how much you love him and by using a condom he may think you do not trust him and will leave you for another girl,' and this 'fear of rejection, desire for acceptance and the need for intimacy' will make them go for unprotected sex, while another one said 'I want to experience what is always said by others'.

4.2.2. Barriers to HIV prevention

Through the focus group discussion the female adolescents brought out why it is usually that difficult for them to practice HIV preventive behaviour as they explained what usually happens when female adolescents get into relationships. Below are some excerpts from the focus group discussions among adolescent school girls:

It is like they want to fit into the society where nowadays the normal thing is, 'in all healthy relationships sex has to be part of it. Young girls are often afraid to lose their boyfriends who insist that if the girls love them, then they should consent to sex, failure of which would result in the boys moving on to the next girl'

Peer pressure was particularly singled out as a major influence in determining adolescents' behaviour patterns in terms of their sexuality:

Peer pressure may also force the initially unwilling girls into early sexual debut and quite often in unprotected sex. A girl would have sex because the other girls of her age are already doing it and they may think it strange for her not to do it too. She may even be chucked out of the group because they think she is backward or too righteous. And usually when the young girls get involved in unprotected sex they are getting half of the information from the older girls but then they would not give them information on the importance of using protection and how to protect themselves.

4.2.3 Custom, division of labour and female sexuality

About communication sex role relationships the female adolescents admitted that in a sexual encounter custom dictates that a "good" girl should play passive and the boy initiates every sex move:

The boy makes most of the decisions on where, when and how they have sex. It is often awkward for a girl to be found initiating the use of a condom. The boy might think that the girl is loose or has been sleeping around and girls do not want to pass that picture to the boys they are going out with… can't propose having sex to my guy even when I want to, neither can I say yes if he proposes, let alone propose condom use. Should a girl suggest the use of a condom the boy may feel offended and think that the girl does not trust him or that she is too forward.

Socio economic factors were also cited as a contributing factor that makes it difficult for the female adolescent to take the initiative to abstain, be faithful or even condomise-:

Some of us live in child headed households and as such one has to fend for the siblings she is looking after and in that case one will be forced to have multiple partners and some even older than her , the so called 'sugar daddies' and the decision on whether to protect or not is his.

Economic vulnerability that comes with orphan hood tends to compound the problems for the female adolescent.

Respondents unanimously agreed that they really do not know who to talk to in relation to problems they usually face as adolescents as they lamented that the social fabric which appears to have now gone beyond repair no longer avails them an opportunity to talk to their aunts like what they hear used to happen in the past. One respondent had this to say:

We hear that long back aunts and sometimes grandmothers would bring young girls together and issues on growing up would be discussed. It would then become easier for you to go back to your aunt or grandmother should you come across any problems related to you as an adolescent and if a girl had a boyfriend we hear you were supposed to take him to your aunt and guidance would be given for good courtship. Nowadays there is no one for us you cannot discuss things like this with your mother.

4.3. Results from the in-depth interviews

Key informants do agree that the effort to impart knowledge from the formal system like the schools and the youth friendly clinics were made only in the early years of HIV discovery and died a natural death as the country went through economic hardships and if people were beginning to sit in at workplaces, then it would have meant little sense in putting extra efforts in this new area as there was not enough training and no incentives associated with the added workload. They also mentioned the fact that although issues that supposed to be discussed either in the HIV/AIDS lessons or in the youth friendly units included growing up, sex and sexuality issues, HIV/AIDS, sexually transmitted infections, assertiveness just to mention a few, no one is seen to be seriously playing their role and information ends up being given informally.

On access to information for these female adolescents, the media, and peers and for a few others, senior lady teachers and the teachers from the guidance and counselling department were easily accessible. Key informants agreed that even for them as parents it was difficult to discuss issues to do with condom use with their children at home as it would appear like ‘you are giving them a go ahead to have premarital sex. A few respondents basically from the medical field indicated that they can talk freely about sex and sexuality issues with the few adolescents who happen to ask any questions related to this topic even indicating that for the few who come for STI

treatment they find it necessary to give information on condom use, importance of HIV testing although few welcome the idea of getting HIV tested.

Generally, most of the key informants agreed that these female adolescents have high knowledge levels of HIVAIDS, modes of transmission and the ABC model of HIV prevention but their perception of risk seems to be low a can be observed from their sexual behaviours , unplanned pregnancies and STI infections especially as observed from those who then come for treatment. It appears it was a general consensus that the female adolescents do not have enough information that to help that develop a positive attitude that would help to translate what they know in to action. ‘People generally do not want to be talk about it’, ‘girl children are not empowered and most sexual debut for the female adolescents is usually forced’, ‘no one is providing the necessary skills as they are maturing early and just that closeness they also want to feel is taken advantage of by men as they ‘turn jelly’ in these early sexual relationships’. These were some o f the sentiments from the key informants.

The noted barriers to HIV preventive sexual behaviours included lack of the correct information on HIV prevention, peer pressure, attitude of parents and leaders towards sex education and access to condoms, attitude of service providers who instead of reprimanding somehow label those who come for STI treatment, lack of clear cut policies, socioeconomic factors, cultural and religious beliefs that somehow reinforce the imbalances of power in sexual relationships and promote male dominance of women.

4.4 Discussion

The findings presented in this study represent only a tip of the ice-berg considering the fact that the time that was given for the study was not enough especially when one considers the fact that for a person to open up they need to develop trust in the person they are talking to. Meeting respondents for only two sessions could not have been enough for them to feel comfortable to say things that are this sensitive as was the topic under study. However it can be argued that the study has tried to uncover some of the obstacles the female adolescents face in practicing HIV preventive behaviour. It has highlighted the importance and centrality of gender dimensions and the social and cultural context as a factor in shaping the youth's sexual behaviour. In rethinking behaviour change communication strategies it is important to listen to the voices of those at the bottom of the social strata. Space needs to be given for the female adolescents to participate in the design and implementation of any interventions meant to help them (Barrow 2007).

Findings have shown that there is a positive relationship between HIV/knowledge and a positive predisposition towards HIV prevention, but putting this knowledge then into practice is what then becomes a challenge as was revealed by findings from the focus group discussions. Responses on attitude towards HIV prevention and risky sexual behaviours show that respondents have a positive attitude towards HIV prevention through health sexual behaviours. However, the findings confirm that knowledge alone and a positive attitude towards HIV prevention is not enough to cause behaviour change given the societal or environmental context within which the HIV preventive behaviour is to be practiced, no wonder why although just 17 respondents (16, 2%) admitted being sexually active, yet statistics from the clinics give evidence to the contrary. There is a high probability that the low levels of sexually active female adolescents shown from the survey results rather than being proof of effective application of the abstinence as a preventive measure it may be nothing but an artefact of a poor question item. It is highly probable that from the ABC repertoire of preventive strategies abstinence and delayed onset of sexual activity presents the female adolescent with agency and carries the greatest promise for HIV prevention given a supportive environment. Abstinence therefore would go a long way as early sexual exposure is associated with higher risks of HIV infection and the ability to delay sexual debut through abstinence would also help in developing negotiating skills for

condom use if sex is delayed till the female adolescent is mature enough to argue their way to safe motherhood.

The findings on condom use and accessibility in HIV prevention again show that knowledge on its own is not enough as focus group discussions revealed. The power in peer pressure cannot be underestimated both in a negative and a positive sense. Female adolescents become curious to 'experience what others say it feels like to have unprotected sex'; they may know that condoms provide some protection and they may be aware where to get the condoms but because peers say 'it feels good without a condom', they want to try it. On the other hand peer influence may work for good where recognition and reward follows good role models. This is probably important for preventive interventions to consciously employ the social and group dynamics among youths to promote healthy sex behaviours. The fear to lose a relationship, the so called trust in the so called steady relationships, the urge to express love to a sexual partner has emerged as strong barriers to HIV prevention through health sexual behaviours. Female adolescent's resolve to abstain often gets shattered the moment they have to choose between either giving in to sexual advances of a lover and being rejected.

Culturally the female adolescent has been socialized to respect man on every turn, from the home she grows up in, the little brother is respected as the future head of this family and enjoys all the favours that go with that respect. Female docility as a value is inculcated in the home, the church, at play, in school, the media and many other agents of socialization. The study has identified among other things power imbalances in sexual relationships that make it difficult for the female adolescent to exercise the ABC model of HIV prevention for example. Effort is not being put to correct this imbalance like what another study suggested that in as much as we are teaching the female adolescent to delay the onset of sexual activities by saying 'NO' to sex, we should be also teaching the man to accept the 'NO' as a corrective measure. Negotiation skills to help them to be assertive need to be addressed so that they are empowered to say NO when they mean NO to unprotected sex and not to say 'NO when they mean to say YES'.

Female adolescents' sexuality needs to be taken seriously and not to be ignored or simply wished away. HIV/AIDS preventive interventions need to be sensitive to and responsive to the

challenges female adolescents actually say they face socially, culturally and religiously as they struggle to use the top-down intervention strategies that have been in place for some time now.

CHAPTER 5

Recommendations and Concluding Remarks

5.1. Recommendations

HIV the virus that causes AIDS has no cure and if leaves one in double jeopardy if one is HIV positive and one is a woman as our communities continue to give the problem of HIV/AIDS a gender blind approach. Given the sensitive nature of the subject under study it is not surprising that what is on the ground, that is the statistics from the clinics that reported for year 2008 and the results of this study are two different things especially given the period that was taken for the study, it can be understood that it was too short for nature of such a study. Below are a few recommendations coming up as a result of the findings of this study showing how a multi-pronged approach could be used.

There is need for ethnographic studies that cater for all the ten provinces in Zimbabwe so as to really determine the extent of the problem of the obstacles these female adolescents face in translating HIV/AIDS knowledge in to health HIV preventive behaviours in trying to combat the epidemic.

An attempt should be made to mend the social fabric that upheld values that these female adolescents seem to adore and the starting point could be to work with the parents which are the first socialisation agents the child gets in contact with from birth. To catch them young and target the opportunity window, a model to help parents to develop parent-adolescent communication so that correct information is given on sex and sexuality and that these discussions take place before the first sexual encounter. In such a way parents can provide structure and support as well as provide parental monitoring and guidance that can save the adolescents from peer norms and 'mediate variables like attitude about HIV and abstinence variables and intentions to abstain', given the cultural and religious background that has already ingrained in female adolescents, the desire to abstain till marriage.

The fact that these female adolescents still remain a part of the patriarchal system and its socialization on what 'a good woman is', shows the need for community involvement if there is going to be a change in attitude so that both man and woman work to address the gender imbalances in sexual relationships. It has been taboo to discuss sexual issues and if these communities still regard it as such then even the family which the part of the community has no support and there are chances of a relapse even if the above suggested programme were to kick off.

It is important to train the health service providers so that they create an enabling environment that promotes health sexual behaviours that aim to prevent HIV infection through educative communication. Youth friendly corners need to be revived and staff trained to impart life skills for female adolescents.

These female adolescents spend the greater part of their life at school as long as they are still in-school which means the school personnel, guidance and counselling teachers have a very important role to play. Since structures had already been put in place to provide education on HIV/AIDS and skills education, teachers need to undergo training so that they too are fully informed about HIV/AIDS to empower them to give impart this education. In addition it could be high time each school has a professionally trained counsellor to help these female adolescents in their cry for 'having no one to trust and confide in'.

With such developments in mind, the adolescents themselves need not be left out as we ought not to do things 'for them but with them' in a 'client/person centred' approach. It is very important to involve them in identifying the problems they face and the solutions should also be suggestions coming from them. Alongside this would be the training of the Peer Educators to provide informal education on HIV/AIDS since people are more likely to listen to and follow advice given by their peers. It has been acknowledged that, 'peers have greater influence on each other than non-peers, a significant factor that lends credibility to behaviour change messages'.

Lastly but not least, the involvement of their male counterparts in similar programmes so that they respect a 'No' and also become aware of the rights of girls in relation to their sex and sexuality.

5.2.Concluding remarks

The ABC model's success as a behaviour change intervention is premised on the assumption that females are able to say NO to sex and that their word is culturally respected as such, it is as if saying yes were a viable option for the female adolescent. Encouraging fidelity makes the assumption that both parties to the sex relationship are culturally expected to be faithful. The condom is not gender neutral in the social context of this study and the condom has been appropriated and privatized by men. It is a symbol more associated with the male erection and sexual domination of women by men and as such its use depends on male whim. Thus this discussion points to the need for a new reorientation of behaviour change interventions which are attentive to the voices from below who are the marginalized products of abuse of the gendered power imbalances of our societies, the Female Adolescents and yet they are a part of our window of hope for an HIV free generation.

Chapter 6

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Appendix

QUESTIONNAIRE

Information collected through this questionnaire is for academic purposes only and therefore the answers you will give will be kept strictly in confidence – that means it will be a secret between you and me. No one will know what you tell me, not even your teacher, your friends or your parents/guardian/relatives. **You should therefore not write your name on this questionnaire.** Taking part in the survey is voluntary, that means you do not have to participate if you do not want. There are questions you may not be comfortable in answering, you do not have to answer questions you do not want to and if you do not understand something please let me know so that I can read the question again.
Please express your opinion by ticking the appropriate answer in the answer box and by filling in the blank spaces as required where applicable.

SECTION A
Respondent's Demographic Data

No.	QUESTION	INSTRUCTION	ANSWER	CODE
A1	How old are you?		1 14 yrs	
			2 15 yrs	
			3 16 years	
			4 17 yrs	
			5 18 yrs	
			6 19 yrs	
A2	What Form are you in now?		1 Form 2	
			2 Form 3	
			3 Form 4	
			4 Form 5	
			5 Form 6	
A3	Which religion do you belong to?		0 None	
			1 Christian	
			3 Muslim	
			4 Hinduism	
			5 Buddhism	
			6 Other (specify)	
A4	State suburb/village where you live	……		

No.	QUESTION	INSTRUCTION	ANSWER	CODE
A5	Type of family where you come from		1 Monogamous	
			2 Polygamous	
			3 Single parent(father)	
			4 Single parent (mother)	
			5 Staying with a guardian	
			6 Child headed	
A6	Number of people living in your family		1 One – two	
			2 Three – four	
			3 Five or more	
A7 (i)	Living arrangement		1 Staying alone	
			2 With parents	
			3 With single parent	
			4 In Boarding	
			5 With siblings	
			6 With relatives	
A7 (ii)	Indicate any relatives you live with in the same household	Tick all that applies	1 Uncles	
			2 Aunts	
			3 Cousin brothers	
			4 Cousin Sisters	
			5Nieces	
			6 Nephews	
			7 Grannies	

SECTION B

Assessing Knowledge on HIV/AIDS and Attitude towards HIV Prevention

No.	QUESTION	INSTRUCTION	ANSWER	CODE
B1 (i)	Are you aware of HIV/AIDS?		0 No	
			1 Yes	
B1 (ii)	Is there any difference between HIV/AIDS?		0 No	
			1 Yes	
B2	How do people get HIV (tick all that applies)	Tick all that applies	1 Unprotected sex with an infected partner	
			2 Transfusion of unscreened blood	
			3 Kissing an infected person	
			4 Pricks and cuts with unsterilized sharp objects	
			5 Mosquito bites	
			6 From mother to child	
			7 Other (specify)…… …… ……	
B3	Do you have any relative who …	Tick all that applies	1 is HIV positive	
			2 is living with AIDS	
			3 died of AIDS related illness	
			0 None of all of the above	
B4	The causative agent for HIV is…		1 Bacteria	
			2 Parasites	
			3 Virus	
			4 Wrath of God	
			5 Witchcraft (runyoka)	
			98 Don't know	
			99 No response	
B5	The body's defense system cannot fight AIDS		0 No	
			1 Yes	
			98 Do not know	
			99 No response	

No.	QUESTION	INSTRUCTION	ANSWER	CODE
B6	You can tell if someone has got HIV just by looking at their physical appearance		0 No	
			1 Yes	
			98 Don't know	
			99 No response	
B7	The four body fluids that can transmit HIV are…	Tick all that applies	1 Saliva	
			2 Blood	
			3 Sweat	
			4 Semen	
			5 Vaginal secretions	
			6.Breast milk	
B8	Condoms can be used to prevent HIV infection		0 No	
			1 Yes	
			98 Don't know	
			99 No response	
B9	How effective are condoms in preventing HIV transmission		1 100%	
			2 90%	
			3 50%	
			4 depends on how you use them	
			98 Don't know	
			99 No response	
B 10	If you are faithful to only one sexual partner, you do not get HIV		1 False	
			2 True	
			3 Not too sure	
			98 Don't know	
			99 No response	

No.	QUESTION	INSTRUCTION	ANSWER	CODE
B 11	Where do you get information on HIV prevention?	Tick all that applies	1 Parents	
			2 Friends	
			3 Teacher	
			4 Casual acquaintance	
			5 Sexual partner	
			6 Counsellor	
			7 Relative	
			8 Other…specify	
B 12	Ever got tested for HIV?		0 No	
			1 Yes	
B 13	If yes, did you go with your partner?		0 No	
			1 Yes	
B 14	When last did you get tested?		1 in the last three months	
			2 in the last six months	
			3 in the last 12 months	

SECTION C

Sexual Practices and Barriers to HIV Preventive Sexual Behaviours

At this point I wish to ask you a few questions about your sexuality, I know these questions are sensitive but I need to know in order to understand problems you as an adolescent may have in preventing HIV transmission.

No.	QUESTION	INSTRUCTION	ANSWER	CODE
C1	Are you planning to get married in the near future?		0 No	
			1 Yes in two years to come	
			2 Yes in four years to come	
			98 Don't know	
C2	Have you ever had sex?	If No skip question and go to 14C	0 No	
			1 Yes	
C3	Age at first sex		1 10 -12	
			2 13 - 15	
			3 16 - 19	
			98 Don't know	
			99 No response	
C4	Age of person with whom you had your first sexual intercourse with		1……..years	
			98 Don't know	
			99 no response	
C5 (i)	Did you use a condom on this encounter?		0 No	
			1 Yes	
C5 (ii)	If No what were the circumstances that made it impossible for you to use condoms	Use the spaces provided for your answer	……..... ..... …… ……..	
C5 (iii)	If Yes use the provided space to explain who initiated the use of the condom and how where it was obtained?	Use the spaces provided for your answer	…… ……..… …… ……	

No.	QUESTION	INSTRUCTION	ANSWER	CODE
C6	Ever since then with how many sexual partners have you had sexual intercourse with?		1 One	
			2 More than two but less than five	
			3 Above five	
			98 Don't know	
			99 No response	
C7 (i)	Ever had sex while drunk?	If No skip question go to question C8	0 No	
			1 Yes	
			98 Don't know	
			99 No response	
C7 (ii)	If Yes did you use a condom?		0 No	
			1 Yes	
			98 Don't know	
			99 No response	
C8 (i)	Do you currently have a sexual partner(s)?	If No skip this question and go to Question C10	0 No	
			1 Yes	
C8 (ii)	The last time you had sex did you use a condom?		0 No	
			1 Yes	
C9	Do you currently have more than one sexual partner (including your regular partner)?		0 No	
			1 Yes	
C10 (i)	Ever exchanged money for sex?	If No skip and go on to Question C11	0 No	
			1 Yes	
C10 (ii)	If Yes did you use a condom?		0 No	
			1 Yes	
C11	Indulging in unprotected sex with your partner shows that you love him		0 No	
			1 Yes	
			98 Don't know	
			99 No response	

No.	QUESTION	INSTRUCTION	ANSWER	CODE
C12	How many sexual partners have you had in the last 12 months?	If none skip and go to question 14C	0 None	
			1 Total number…….	
			98 Don't know	
			99 No response	
C13	How often did you /your partner use a condom in the last three months?		0 Never used	
			1 Used half or less than half the time	
			2 Used more than half the time	
			3 Used all the time	
			98 Don't know	
			99 No response	
C14 (i)	Ever heard about how you can protect yourself from getting HIV?	If No skip and go on to Question 15C	0 No	
			1 Yes	
C14 (ii)	If yes who told you about protection against HIV/AIDS?	Tick all that applies	1 Partner	
			2 Parent/Guardian	
			3 Sibling	
			4 Relative	
			5 Teacher	
			6 NGO staff	
			7 Healthcare service Provider	
			8 Through the media e g radio, TV, newspaper etc.	
C15 (i)	Is it easy to say NO to sex?		0 No	
			1 Yes	
C15 (ii)	If you think No use the space provided to explain what makes it difficult for you to say no	Use the spaces provided for your answer	…… …… …… ……	
C16 (i)	Would it be easy for you to carry condoms around in case you have sex/with your partner?		0 No	
			1 Yes	

No.	QUESTION	INSTRUCTION	ANSWER	CODE
C16 (ii)	If No explain why	Use the spaces provided for your answer	…… …….. …… ……	
C16 (iii)	Are condoms easily accessible for you?		0 No	
			1 Yes	
C16 (iv)	If yes indicate where you usually get them from	Use the space provided for your answer	…… …… …… …….	
C17 (i)	With whom would you openly discuss issues to do with sex?	Tick all that applies	0 No one	
			1 Parent/guardian	
			2 Sexual partner	
			3 Peers/Friends	
			4 Teacher	
			5 Counsellor	
			6 Relative (specify)…….	
C17 (ii)	If no one explain what makes it difficult for you to discuss such issues	Use the spaces provided for your answer	…… …… …… …….	

D Attitude towards HIV Prevention and Sexual Practices

Indicate your opinion on each of the following questions by ticking in the box that closely matches your view.

1) There is nothing wrong with boys and girls who love each other having sex even before marriage				
Strongly agree	Agree	Not decided	Disagree	Strongly disagree

2) There is no link between having multiple partners and the high risk of getting HIV infection				
Strongly agree	Agree	Not sure	Disagree	Strongly disagree

3) HIV/AIDS education in schools is very important in the prevention of HIV/AIDS infection				
Strongly agree	Agree	Not sure	Disagree	Strongly disagree

4) My family (father, mother, siblings, other relatives or guardians) are important people in helping me prevent HIV infection and therefore should openly talk to me about sexual issues				
Strongly agree	Agree	Not sure	Disagree	Strongly disagree

5) Men who have sex with girls without using condoms should be arrested				
Strongly agree	Agree	Not sure	Disagree	Strongly disagree

6) Delaying onset of sexual activities by abstaining is an effective way of preventing HIV infection for female adolescents.				
Strongly agree	Agree	Not sure	Disagree	Strongly disagree

7) Male sexual partners are the ones who should always carry condoms on them in case the two lovers decide to have sexual intercourse				
Strongly agree	Agree	Not sure	Disagree	Strongly disagree

Conclusion

E 1 Are there any issues you would like to discuss with me that are related to female adolescents sex and sexuality and HIV/AIDS Prevention Obstacles?

……...
……
……

E 2 Are there any questions you would like to ask before we close this session again in relation to sex and sexuality and female adolescents and HIV/AIDS Prevention Obstacles

……
……
……

E 3 Do you think you would like to take part in a small Group discussion on this subject in the future……

Thank you. This is the end of the survey. I really appreciate you taking time to respond to these questions.